4 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, We may collect such amounts directly from you. You agree that We have the right to collect such amounts from you.

Essential Health Benefits provided within this Certificate are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

BENEFIT PERIOD	Calendar Year

DEPENDENT AGE LIMIT	To the end of the month the child attains age 26
PRE-EXISTING PERIOD	For any Pre-Existing Conditions in existence 6 months prior to your Enrollment Date, the services, supplies or other care related to the Pre-Existing Condition(s) are not covered for 12 months after your enrollment. Pre-Existing exclusions or limitations do not apply to Member's under the age of 19.

DEDUCTIBLE

	Network	**Non-Network**
Per Member	$2,500	$5,000
Per Family	$7,500	$15,000

NOTE: The Deductible applies to all Covered Services with a Coinsurance amount you incur in a Benefit Period except for the following:

- Emergency Room services when subject to a Copayment plus Coinsurance

Copayments are not subject to and do not apply to the Deductible.

OUT-OF-POCKET LIMIT

	Network	**Non-Network**
Per Member	$4,000	$8,000
Per Family	$12,000	$24,000

NOTE: The Out-of-Pocket Limit includes all Deductibles and Coinsurance amounts you incur in a Benefit Period except for the following services:

- Prescription Drug benefits
- Non-Network Human Organ and Tissue Transplant services

Copayments do not apply to the Out-of-Pocket Limit.

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for the services listed above.

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are separate and do not accumulate toward each other.

COVERED SERVICES	**COPAYMENTS/COINSURANCE/MAXIMUMS**	
	Network	**Non-Network**
Ambulance Services	20% Coinsurance	20% Coinsurance

Autism Spectrum Disorders Maximum per month, per Member ages one (1) through twenty-one (21)	Benefits applicable to service provided $1,000 Network and Non-Network combined	
Behavioral Health Services		
Inpatient Services	20% Coinsurance	Substance Abuse-50% Coinsurance Mental Health-Not Covered
Outpatient Services	20% Coinsurance	50% Coinsurance
Physician Home Visits & Office Services	20% Coinsurance	50% Coinsurance
MAXIMUMS		
Lifetime:	Two Inpatient & Outpatient Substance Abuse rehabilitation programs per lifetime	
Benefit Period:		
Inpatient Mental Health and Substance Abuse days per Benefit Period:	30 days	Mental Health - Not Covered Substance Abuse - 1 day Alcoholism: Emergency detoxification — 3 days Residential treatment — 10 days
Outpatient Mental Health and Substance Abuse Visits per Benefit Period:	30 visits	Mental Health - 10 visits Substance Abuse - 10 visits
Dental Services **(only when related to accidental injury or for certain Members requiring general anesthesia)**	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Benefit Period Maximum for Surgical Treatment and anesthesia for Accidental Dental Services	Covered Services are limited to $3,000 per Member per Benefit Period (Network and Non-Network combined). Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that We are required by law to cover.	
Diabetic Equipment, Education, and Supplies	Copayments / Coinsurance based on setting where Covered Services are received	

	For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this Schedule.	
Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Copayment/Coinsurance. Laboratory services provided by a facility participating in Our Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of Our Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services Copayment/Coinsurance is waived if you are admitted	$250 Copayment per visit plus an additional 20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Home Care Services	20% Coinsurance	50% Coinsurance
Maximum Visits per Benefit Period	100 visits, Network and Non-Network combined	

NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing Maximum per Member per Benefit Period Lifetime Maximum	$50,000 $100,000	
Hospice Services	Our payment will be no less than Medicare for this benefit.	Our payment will be no less than Medicare for this benefit.
Inpatient and Outpatient Professional Services	20% Coinsurance	50% Coinsurance
Inpatient Facility Services	20% Coinsurance	50% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Network and Non-Network	
Maximum days per Benefit Period for Skilled Nursing Facility	90 days, combined Network and Non-Network	
Mammograms (Outpatient)		
• Diagnostic mammograms	No Copayment / Coinsurance up to the Maximum Allowable Amount	50% Coinsurance
• Routine mammograms	Please see the "Preventive Care Services" provision in this Schedule.	
Maternity Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	20% Coinsurance	50% Coinsurance
Hearing Aids and Related Services (for Members under 18 years of age)	One hearing aid per hearing impaired ear every 36 months.	

NOTE: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services		
Outpatient Surgery Hospital / Alternative Care Facility	20% Coinsurance	50% Coinsurance
Other Outpatient Services	20% Coinsurance	50% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	20% Coinsurance	50% Coinsurance
Specialty Care Physician (SCP)	20% Coinsurance	50% Coinsurance
Online Clinic Visits	20% Coinsurance	50% Coinsurance
Allergy Injections	$5 Copayment per visit	50% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services" in the Certificate) received in a Physician's office are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayment / Coinsurance up to the Maximum Allowable Amount	Copayments / Coinsurance based on setting where Covered Services are received
Surgical Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Copayments / Coinsurance based on setting where Covered Services are received	

Therapy Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

You will not have to pay a Copayment or Coinsurance for Covered Services, rendered for each date of service, from an Occupational Therapist or Physical Therapist that is greater than the Copayment or Coinsurance you would pay for Covered Services from a Primary Care Physician.

Maximum Visits per Benefit Period for:	
Physical Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Manipulation Therapy	12 visits combined Network & Non-Network
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network When rendered in the home, Home Care Services limits apply.

Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	
Urgent Care Center Services	20% Coinsurance	50% Coinsurance
Allergy injections	$5 Copayment per visit	50% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment / Coinsurance will be applied when the injection(s) is billed by itself. The Urgent Care Center visit Copayment / Coinsurance will apply if an Urgent Care Center visit is billed with an allergy injection.

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**

- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Member cost shares.

Transplant Benefit Period	**Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a Network Transplant Provider Facility.	**Non-Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
Deductible	**Network Transplant Provider** Not Applicable	**Non-Network Transplant Provider** Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider
	During the Transplant Benefit Period, No Co-payment / Coinsurance up to the Maximum Allowable Amount Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, You will pay 50% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will **not** be responsible for Covered Services which exceed Our Maximum Allowable Amount. If the Provider is a Non-Network Provider for this Certificate, you **will** be responsible for Covered Services which exceed Our Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	No Copayment / Coinsurance up to the Maximum Allowable Amount	You are responsible for 50% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as approved by the Plan, up to a $10,000 benefit limit	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a $30,000 benefit limit	Covered, as approved by the Plan, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services Donor benefits are limited to benefits not available to the donor from any other source.	Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	You will pay 50% of the Maximum Allowable Amount for Medically Necessary live organ doner expenses. These charges will NOT apply to your Out-of-Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network)	30
Mail Service	90
Retail Specialty Pharmacy (Network & Non-Network) and Specialty Mail Service	30* See additional information in Specialty Network Retail / Specialty Mail Service section below.

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:	
Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	$25 Copayment per Prescription Order
Tier 3 Prescription Drugs	$40 Copayment per Prescription Order
Tier 4 Prescription Drugs	Not available at Retail Pharmacies. See Specialty Network Retail / Specialty Mail Service information below.

The PBM's Mail Service Program Prescription Drug Copayment/Coinsurance:	
Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	$65 Copayment per Prescription Order
Tier 3 Prescription Drugs	$120 Copayment per Prescription Order
Tier 4 Prescription Drugs	See Specialty Network Retail / Specialty Mail Service information below.

Specialty Network Retail, Including Specialty Mail Service Program, Prescription Drug Copayment / Coinsurance:

*Note: Certain Specialty Drugs in Tiers 1–3 (including but not limited to oral HIV drugs and immunosuppressant drugs) may be dispensed in up to a 90-day supply, subject to the Mail Service Copayments listed above. When a 30-day supply is obtained, the Copayments listed below will apply. Specialty Drugs in Tier 4 are limited to a 30-day supply.

Tier 1 Specialty Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Specialty Prescription Drugs	$25 Copayment per Prescription Order
Tier 3 Specialty Prescription Drugs	$40 Copayment per Prescription Order
Tier 4 Specialty Prescription Drugs	25% Coinsurance, maximum $150 per Prescription Order, subject to a $2,500 calendar year Prescription Drug Out of Pocket Maximum for Tier 4 Drugs

Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment:	50% Coinsurance (minimum $40) per Prescription Order

Note: Prescription Drugs will always be dispensed as ordered by your Physician. You may request, or your Physician may order, the Tier 2 or Tier 3 Drug. However, if a Tier 1 Drug is available, you will be responsible for the difference in the cost between the Tier 1 and Tier 2 or Tier 3 Drug, in addition to your Tier 1 Copayment. If a Tier 1 Drug is not available, or if your Physician writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only be required to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Tier 1 and Tier 2 or Tier 3 Prescription Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics saves money, yet provides the same quality. We reserve the right to remove certain higher cost Generic Drugs from this policy.

Defining Essential Health Benefits

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014. Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories:

(1) ambulatory patient services,
(2) emergency services,
(3) hospitalization,
(4) maternity and newborn care,
(5) mental health and substance use disorder services, including behavioral health treatment,
(6) prescription drugs,
(7) rehabilitative and habilitative services and devices,
(8) laboratory services,
(9) preventive and wellness services and chronic disease management, and
(10) pediatric services, including oral and vision care.

Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.

Mental Health and Substance Use Disorder Services and Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits.

Under the ACA, coverage for mental health and substance use disorder services must be consistent with the requirements of the MHPAEA. The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment.

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Autism Spectrum Disorders

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The diagnosis and treatment of Autism Spectrum Disorders for Members ages one (1) through twenty-one (21) is covered. Autism Spectrum Disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Treatment for autism spectrum disorders includes the following care for an individual diagnosed with any of the autism spectrum disorders:

- Medical care - services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care - professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;

- Pharmacy care, if covered by the Plan - Medically Necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority, if covered by the plan, and any medically necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care - direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
- Therapeutic care - services provided by licensed speech therapists, occupational therapists, or physical therapists; and
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior

No reimbursement is required under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Provided to the Member by a publicly funded program;
- Performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services provided by persons who are not licensed as required by law.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include but are not limited to:

- **Inpatient services** - individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. If you or your Non-Network or Blue Card Provider do not obtain the required Precertification, as described under the "Health Care Management" section of this Certificate, a Retrospective review will be done to determine if your care was Medically Necessary. If We determine the services you receive are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a participation agreement with Us, you will be financially responsible for the services.
- **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- **Outpatient treatment, or individual or group treatment** - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.
- **Residential Treatment services** - Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

Non-Covered Behavioral Health Services (please also see the Exclusions section of this Certificate for other non Covered Services)

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for your condition.
- Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

Coinsurance, Copayments and limits are specified in the Schedule of Benefits.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise Covered Services under this Certificate and the clinical trial meets all of the following criteria:

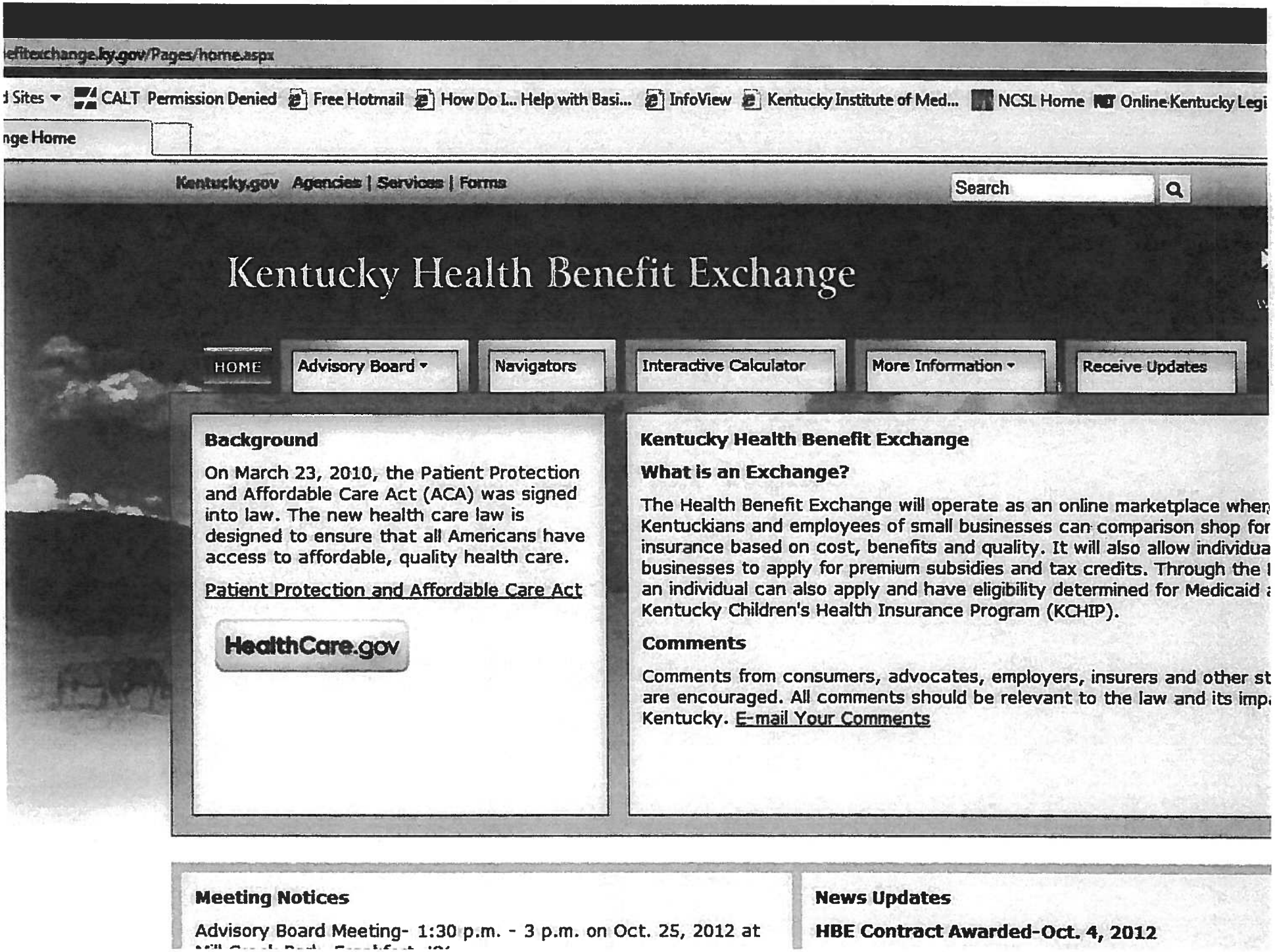
- The trial is approved by one of the following:
  1. The National Institutes of Health, or any institutional review board recognized by the National Institutes of Health;
  2. The United States Food and Drug Administration;
  3. The United States Department of Defense; or
  4. The United States Veterans Administration; and
- The trial does one of the following:

Exchange Grant Funds Received

- August 2010 - $1M Planning Grant (research policy options, analyzed insurance market, collaborated with other state agencies and assessed IT system capabilities).
- August 2011 - $7.6M Level I Establishment Grant (defining system requirements for Exchange and new Medicaid eligibility systems, and developed IT RFP).
- February 2012 - $57.8M Level I Establishment Grant (begin IT development and implementation of Medicaid and Exchange systems).
- October 2012 - $4.5M Level I Establishment Grant (staffing cost, Navigator program, workforce study).

KHBE Implementation Update 2012

- May – present – on going meetings with stakeholders and public speaking engagements to solicit input and educate.
- July & August – Public Forums in Erlanger, Louisville, Owensboro, Paducah, Prestonsburg, and Somerset. More scheduled for 2013.
- September – Advisory Board members (19) appointed.
- September – Website healthbenefitexchange.ky.gov launched.
- October – EHB benchmark plan submitted to HHS.
- October – Contract signed with IT vendor (Deloitte).
- October – Agreement signed with marketing and outreach vendor (Doe Anderson).
- November 15 – Level II grant application to be filed with HHS for additional funding for remaining IT system build and implementation.
- November 16 – Blueprint Application to establish a state-based Exchange must be filed with HHS.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Kentucky.gov Agencies | Services | Forms
Search
Kentucky Health Benefit Exchange
HOME
Advisory Board
Navigators
Interactive Calculator
More Information
Receive Updates
Background
On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. The new health care law is designed to ensure that all Americans have access to affordable, quality health care.
Patient Protection and Affordable Care Act
HealthCare.gov
Kentucky Health Benefit Exchange
What is an Exchange?
The Health Benefit Exchange will operate as an online marketplace when
Kentuckians and employees of small businesses can comparison shop for
insurance based on cost, benefits and quality. It will also allow individua
businesses to apply for premium subsidies and tax credits. Through the
an individual can also apply and have eligibility determined for Medicaid
Kentucky Children's Health Insurance Program (KCHIP).
Comments
Comments from consumers, advocates, employers, insurers and other st
are encouraged. All comments should be relevant to the law and its imp
Kentucky. E-mail Your Comments
Meeting Notices
Advisory Board Meeting- 1:30 p.m. - 3 p.m. on Oct. 25, 2012 at
News Updates
HBE Contract Awarded-Oct. 4, 2012